EndeavorRx™

Enrollment Form

This form allows you to initiate and fulfill an EndeavorRx™ prescription.

Please complete and fax **all sections** of this form to Akili Assist™ at **1-866-565-4633** to initiate your patient's prescription for processing.

PATIENT INFORMATION

Patient first name	Patient middle name	Patient last name	Date of birth

Gender ☐ Male ☐ Female ☐ Other	Address	City	State	Zip

Caregiver / Legal Guardian Information

First name	Middle name	Last name	Relationship to patient

Phone number	Phone Type ☐ Cell ☐ Home ☐ Office	Email address

Preferred method ☐ Phone ☐ Email ☐ Both	Preferred contact time ☐ Morning ☐ Afternoon ☐ Evening	I consent to being contacted via text/SMS message ☐ Yes ☐ No

☐ I confirm the patient has access to a supported iOS device (Apple iPhone or iPad)

INSURANCE INFORMATION

Pharmacy plan	Subscriber ID #	Group #	Phone #	PCN #	BIN #

Primary insurance	Subscriber ID #	Group #	Phone #	Policy holder

CAREGIVER & PATIENT AUTHORIZATION AND CONSENT FOR TREATMENT

We need your permission to provide your child with EndeavorRx™ treatment and to use and disclose the information provided on this Enrollment Form and during this enrollment process (the "Enrollment Information"). This Authorization and Consent agreement ("Authorization") covers the ways in which Akili Interactive Labs, Inc. and our partners, such as our call center and data storage partners (together, "Akili," "us," "our," or "we"), may use, exchange, collect, and disclose the Enrollment Information, including with, from, and to the pharmacy that fills the prescription and your child's healthcare professional (the "Authorized Parties").

When you register to use one of Akili's software apps, you will also be asked to accept our Privacy Policy, which further explains how we collect, use, disclose, and safeguard your information, and is located here: https://my.akili.care/privacy.

How will your Enrollment Information be used and disclosed?
By signing this Authorization, you give Akili and the Authorized Parties permission to confidentially collect, use, exchange, and disclose Enrollment Information, for example your and your child's name, address, diagnosis, DOB, and healthcare professional information, for purposes related to your enrollment with Akili and the patient's treatment with EndeavorRx™ such as:

- to enable us to provide personalized treatment for the patient;
- to communicate with you regarding enrollment, pricing, prescription information, treatment, or any product recalls or modifications;
- to communicate with your healthcare professional to confirm, obtain, or update your child's prescription for EndeavorRx™, regarding your child's treatment, and to help us complete any missing information on this Enrollment Form;
- to facilitate any applicable payment for EndeavorRx™; and
- if you separately request, so that we may determine your eligibility for our Patient Assistance Program, which may help cover all or part of the cost of treatment.

We may send the communications via phone, email, or SMS (unless you have not opted in for, or have opted out of, SMS), including using an automated dialer. Message and data rates may apply. You may opt out of any SMS messages by responding with "STOP". To receive help, respond via SMS with "HELP".

Akili may also use or disclose Enrollment Information:

- to carry out our legal responsibilities, protect our legal rights, or investigate suspected wrongdoing; and
- confidentially in the event of a corporate change in control resulting from, for example, a merger, sale of assets, or bankruptcy.

Once Enrollment Information has been disclosed in any of the ways described herein, federal and state privacy laws may no longer protect such information, but we will take measures to keep your information confidential.

What if I have additional questions?
Our Akili Assist™ team is here to help. Please call 1-844-AKILI-IQ (1-844-254-5447) Monday through Friday between 9:00am and 8:00pm ET, email info@akiliinteractive.com, or visit AkiliAssist.com

By signing below, I attest that: I am at least 18 years old; I am the parent or legal guardian of the patient identified on this form; I have read, understand, and agree to the uses and disclosures of Enrollment Information described above; and I authorize Akili and the Authorized Parties to provide the patient identified above with EndeavorRx™ and support services.

Caregiver / legal guardian signature	Caregiver / legal guardian name printed	/ / Signature date	Relationship to patient

Please note: Submitting this enrollment form is not a guarentee of coverage or reimbursement

ADDITIONAL CAREGIVER CONSENT FOR REIMBURSEMENT SUPPORT

We can help with reimbursement for EndeavorRx™! By signing this additional consent, you permit us to contact your insurance provider and disclose the Enrollment Information necessary to inquire about coverage. You also permit your insurance provider to share with us your applicable plan or other insurance information, and you permit your healthcare professional to share with us any additional treatment information necessary to assist you in seeking reimbursement.

Once your insurance provider or healthcare professional has shared such information with us, that information may no longer be protected by federal privacy law, but we will take measures to keep your information confidential.

You do not have to sign this additional consent. If you choose not to sign, it will not affect your ability to receive EndeavorRx™, but we will not be able to provide reimbursement support. You may revoke this additional consent at any time by contacting Akili Assist™ at info@akiliinteractive.com or 1-844-AKILI-IQ (1-844-254-5447). You may receive a copy of this form.

This consent will expire one year from the date of your signature below.

Caregiver / legal guardian signature	Caregiver / legal guardian name printed	Signature date	Relationship to patient
		/ /	

HEALTHCARE PROVIDER INFORMATION

NPI #	First name	Middle init.	Last name	Facility name

Phone #	Fax #	Email	Preferred method of contact ☐ Phone ☐ Email ☐ Fax

Facility address	Apt./Suite	City	State	Zip

Primary contact name	Primary contact #	Primary contact position

PRESCRIPTION

Patient first name	Patient last name	Date of birth	Refills ☐ 1 ☐ 2 ☐ 3 ☐ 4

Diagnosis / Primary ICD-10 code

- ☐ **F90.0**, Attention-deficit hyperactivity disorder, predominantly inattentive type
- ☐ **F90.1**, Attention-deficit hyperactivity disorder, predominantly hyperactive type
- ☐ **F90.2**, Attention-deficit hyperactivity disorder, combined type
- ☐ **F90.8**, Attention-deficit hyperactivity disorder, other type
- ☐ **F90.9**, Attention-deficit hyperactivity disorder, unspecified type
- ☐ **Other** (please write in) _____

Prescription selection

- ☐ **3-month digital care program treatment**; Dispense: One access code good for 3-months of access (96 days supply)

Directions (required)

- ☐ **25 mins/day, 5 days/week for 4 weeks with a break of up to 4 weeks, followed by another 4 weeks of 25 mins/day, 5 days/week** (Per EndeavorRx Instructions for Use)
- ☐ **Other:** _____ Mins/day _____ Days/week _____ # of weeks* _____ length of break (if any) in weeks

*Minimum of 4 weeks recommended

PHYSICIAN ATTESTATION

Note to healthcare provider: please ensure that the method by which you prescribe this treatment complies with all applicable laws and regulations, including any relating to electronic prescriptions.

I certify that I have reviewed this therapy with the patient and caregiver. I understand that representatives from Akili Interactive may contact me or my patient's caregiver for additional information relating to this prescription.

Prescriber signature*	Physician name printed	Signature date
		/ /

*Prescriber attests that this is his/her legal signature. Rubber stamps, signature by other office personnel for the prescriber, and computer-generated signatures will not be accepted.

Dispense as Written. Do not substitute.

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Questions? Our Akili Assist representatives are here to help.
Give us a call at 1-844-AKILI-IQ (1-844-254-5447)
Mon to Fri: 9 am - 8 pm ET
Fax number: 1-866-565-4633 PO Box 1517, Woodstock, GA 30188

Only residents within the US and its territories can receive a presctiption at this time. If you are a resident of the US or a US territory and your address does not match the format on this form, please contact Akili Assist.

Please note: Submitting this enrollment form is not a guarentee of coverage or reimbursement